Idaho HCBS, (Home and Community Bases Services), Medicaid

Orientation Guide

General Information
Part I

Idaho Department of Health and Welfare
Division of Medicaid
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IDAHO DEPARTMENT OF HEALTH & WELFARE

Introduction:

This Idaho HCBS Medicaid Provider Orientation Guide was developed to assist Home and Community Based Services Waiver and Personal Care Service agency applicants better understand Medicaid Program requirements.

Part I of the Orientation Guide provides a 12 chapter introduction to Idaho Medicaid and related topics.

Part II of the Orientation guide defines specific Medicaid programs offered in Idaho.

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Part I

Chapter 1 General Medicaid Information

1.1 What is Medicaid?

History: Title 19 of the Social Security Act, "Grants to States for Medicaid Assistance Programs," was signed into law by President Johnson on July 30, 1965. Prior to the passage of this law, health care services for the indigent were provided primarily through a patchwork of programs sponsored by state and local governments, charities, and community hospitals.

1.2 Medicaid Defined:

The Medicaid Program is a jointly funded cooperative venture between the Federal and State governments to assist states in the provision of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health related services to America's poorest people. The Federal statute identifies over 25 different eligibility categories for which federal funds are available. These statutory categories can be classified in to five broad coverage groups:

- Children
- Pregnant Women
- Adults in Families with Dependent Children
- Individuals with Disabilities
- Individuals 65 or over

Within broad national guidelines established by Federal statutes, regulations, and polices, each state:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

1.3. Basis of Eligibility: *Medicaid does not provide medical assistance for all poor persons.* Under the broadest provisions of the Federal statute, Medicaid does not provide health care services even for very poor persons unless they are in one of the designated mandatory groups or in an optional group the state has elected to cover. *Low income is only one test for Medicaid eligibility.*

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, however, States are *required* to provide Medicaid coverage for certain individuals who receive Federally assisted income-maintenance payments as well as for related groups not receiving cash payments.

All states *must* provide Medicaid coverage to the following eligibility groups:

- Aid to Families with Dependent Children – eligible individuals as of July 16, 1996: States are required to provide Medicaid to individuals who meet the requirements of the AFDC program that were in effect in their state as of July 16, 1996.
- Poverty-related groups: States are required to provide Medicaid to certain pregnant women and children defined in terms of family income and resources. States must cover all pregnant women, and children below age 6 with incomes up to 133 percent of the federal poverty level.
- All children born after September 30, 1983 with incomes up to 100 percent federal poverty level.
- Foster care and adoption assistance; States must provide Medicaid to all recipients of foster care and adoption assistance under Title IV-E of the Social Security Act.
- Certain Medicare beneficiaries: State Medicaid programs must provide assistance to low-income Medicare beneficiaries. All Medicare beneficiaries with incomes below the poverty level receive Medicaid assistance for payment of Medicare premiums, deductibles and cost sharing. These individuals are Qualified Medicare Beneficiaries, (QI-1s). In addition, individuals at the lowest income levels may have income low enough to qualify for full Medicaid benefits, which provide coverage for services not covered by Medicare such as outpatient prescription drugs. Medicare beneficiaries with income

levels slightly higher than poverty receive Medicaid assistance for payment of Medicare premiums. These individuals are Specified Low-Income Medicare Beneficiaries, (QI-2s).

In addition to their Medicaid programs, most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are not provided for State-only programs.

1.4 Medicaid Services: Medicaid policies for eligibility are complex and vary considerably, even among States of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one State may not be eligible in another State, and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, State legislatures may change Medicaid eligibility and/or services during the year. *As a result, there are essentially 56 different Medicaid programs – one for each state, territory and the District of Columbia.*

To be eligible for Federal funds, States are required to provide Medicaid coverage for certain individuals. For example, a State's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include the following:

- Inpatient hospital services
- Outpatient hospital services
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for persons aged 21 or older
- Family planning services and supplies
- Rural health clinic services
- Home Health care for persons eligible for skilled-nursing services

- Laboratory and x-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Federally qualified health center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21

States may receive Federal matching funds to provide certain *optional* services. Some of the more common approved optional Medicaid services include:

- Diagnostic Services
- Clinic Services
- Intermediate care facilities for the mentally retarded, (ICFs/MR)
- Prescribed drugs and prosthetic devices
- Optometrist services and eyeglasses
- Nursing facility services for children under age 21
- Transportation services
- Rehabilitation and physical therapy services
- Home and community based care to persons with chronic impairments.

1.5 Payment for Medicaid Services: Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee for service basis, or States may pay for Medicaid services through various prepayment arrangement, such as health maintenance organizations, (HMOs). Within Federally imposed upper limits and specific restrictions, each State for the most part has broad discretion in determining the payment methodology and payment rate for services.

Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment.

States may impose nominal deductibles, coinsurance, or co-payments on some Medicaid beneficiaries for certain services. The following Medicaid beneficiaries, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care.

Medicaid is an entitlement program and the federal spending levels are determined by the number of people participating in the program and services provided. Federal funding for Medicaid comes from general revenues. There is no Trust Fund for Medicaid as there is for Medicare Part A or Social Security. The federal government contributes between 50 percent and 83 percent of the payments for services provided under each state Medicaid program.

This federal matching assistance percentage, (FMAP), varies from state to state and year to year because it is based on the average per capita income in each state. States with lower per capita incomes relative to the national average receive a higher federal matching rate. The federal matching rate for administrative costs is uniform for all states and is generally 50 percent, although certain administrative costs receive a higher federal matching rate.

Chapter 2 Definitions and Abbreviations

2.1 Idaho Administrative Code Definitions

Following is a list of selected definitions from various Idaho Administrative Code sections that are used frequently in Medicaid Provider documents and agreements. Please refer to the Idaho Administrative Code Citations below for additional information.

2.2 Idaho Administrative Code Citations

- **IDAPA 16.03.01** – Rules Governing Eligibility for Medicaid for Families and Children: http://www2.state.id.us/adm/adminrules/rules/idapa16/0301.pdf

- **IDAPA 16.03.09** – Rules Governing the Medical Assistance Program: http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

- **IDAPA 16.03.19** - Rules Governing Certified Family Homes: http://www2.state.id.us/adm/adminrules/rules/idapa16/0319.pdf

- **IDAPA 16.03.22** - Rules for Licensed Residential or Assisted Living Facilities: http://www2.state.id.us/adm/adminrules/rules/idapa16/0322.pdf

- **IDAPA 16.03.23** - Rules Governing Uniform Assessments for State-Funded Clients: http://www2.state.id.us/adm/adminrules/rules/idapa16/0323.pdf

- **IDAPA 16.04.11** - Rules Governing Developmental Disabilities Agencies: http://www2.state.id.us/adm/adminrules/rules/idapa16/0411.pdf

- **IDAPA 16.04.17** - Rules Governing Residential Habilitation Agencies: http://www2.state.id.us/adm/adminrules/rules/idapa16/0417.pdf

- **IDAPA 16.05.06** - Rules Governing Mandatory Criminal History Checks: http://www2.state.id.us/adm/adminrules/rules/idapa16/0506.pdf

2.3 Definitions

1. **Abuse.** The non-accidental infliction of physical pain, injury, or mental injury.
2. **Activities of Daily Living.** Bathing, dressing, toileting, transferring, eating, and walking.

3. **Adult.** A person who has attained the age of eighteen (18) years.
4. **Adult Companion Services.** In-home services to insure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site.
5. **Adult Day Care.** A supervised, structured day program, outside the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living.
6. **Advanced Directive.** A written instruction, such as a living will or durable power of attorney for health care, recognized under State Law, whether statutory or as recognized by the courts of the State, and relates to the provision of medical care when the individual is unable to communicate.
7. **Appeal.** A method to insure personal, civil and human rights related to the provision or termination of services in accordance with IDAPA 16.05.03, “Rules Governing Contested Case Proceedings and Declaratory Rulings”.
8. **Assistive Technology.** Any item, piece of equipment, or product system beyond the scope of the Medicaid state plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant.
9. **Assisted Transportation Services.** Individual assistance with non-medical transportation services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation.
10. **Attendant Care.** Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically oriented tasks dealing with functional needs of the participants and accommodating the participant’s needs for long-term maintenance, supportive care or IADLs.
11. **Case Management.** Case Management, (Service Coordination), is an individualized service provided by an employee of a qualified case management provider agency acting in the role of a coordinator of multiple services to ensure that the various needs of the individual are assessed and met. Services are designed to foster independence of the participant and will be time limited.
12. **Certified Family Home.** A family home in which an adult chooses to live who is not able to reside in his own home and who requires care, help in daily living, protection, security, and encouragement toward independence. This

term includes adult foster care homes as well as any home in which care is provided commercially to one (1) or two (2) persons.

13. **Chore Services.** Intermittent assistance including, but not limited to, yard maintenance, minor home repair, heavy housework, sidewalk maintenance and trash removal. Services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer, agency, or third party payor is willing to, or is responsible for, their provision.
14. **Client. (Participant)** A person for whom the State of Idaho, or a program administered by the State of Idaho, pays all or any part of the cost of the person's care.
15. **Consultation.** (1) Services provided by a Personal Assistance Agency to a participant or family member to increase their skills as an employer or manager of their own care. (2) Services to the provider are for the purpose of understanding the special needs of the participant and the role of the caregiver.
16. **Criminal History Check.** The criminal history check is a fingerprint based check consisting of a self-declaration, fingerprints of the individual, information obtained from the Federal Bureau of Investigation, the National Criminal History Background Check system, Bureau of Criminal Identification, the statewide Child Abuse Registry, Adult Protection Registry, Sexual Offender Registry, and Medicaid S/URs exclusion list.
17. **Department.** The state of Idaho Dept. of Health and Welfare (DHW).
18. **Developmental Disability.** A developmental disability means chronic disability of a person which appears before the age of twenty-two (22) years of age and (a) is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism, or other conditions found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and (b) results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, or economic self-sufficiency; and (c) reflects the need for a combination and sequence of special, interdisciplinary or direct care, treatment or other services which are of life-long or extended duration and individually planned and coordinated.

19. **Director.** The Director of the Idaho Department of Health and Welfare.
20. **Durable Medical Equipment (DME).** Equipment other than prosthetics or orthotics, which can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose.
21. **Employer of Record.** An entity which bills for services, withholds required taxes, and conduct s other administrative activities for a waiver program participant. Such an entity is also called a personal assistance agency functioning as a fiscal intermediary.
22. **Employer of Fact.** A participant or representative of a participant who hires, fires, and directs the services delivered by a waiver program provider. This individual may be a family member.
23. **Exploitation.** An action which may include, but is not limited to, the misuse of a vulnerable adult's funds, property, or resources by another person for profit or advantage.
24. **Fiscal Intermediary Services.** Services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered.
25. **Guardian.** A legally-appointed person who has the care of the person or property of another, under Section 66-404, Idaho Code.
26. **Home Delivered Meals.** Meals designed to promote adequate participant nutrition through home delivery of one (1) to two (2) meals per day to persons in their own home, are alone for significant parts of the day, have no regular caretaker for extended periods of time and are unable to prepare a balanced meal.
27. **Home Health Services.** Skilled services, ordered by a physician, are performed by a licensed nurse, registered physical therapist, or a home health aide as defined in IDAPA 16.03.07, Subsection 002.11, "Rules for Home Health Agencies".
28. **Homemaker Services.** Assistance to the participant with light housekeeping, laundry, and assistance with essential errands, meal preparation, and other light housekeeping duties if there is no one else in the house hold capable of performing these tasks.
29. **Home Modifications.** Minor housing adaptations or environmental modifications that are necessary to enable the

participant to function with greater independence in the home, or without which, the participant would require institutionalization.

30. **Implementation Plan.** Written documentation of participants' needs, desires, goals and measurable objectives, including documentation of planning, ongoing evaluation, data-based progress and participant satisfaction of the program developed, implemented, and provided by the agency specific to the plan of service.
31. **Individual Service (IS) Plan.** A document which outlines all services including, but not limited to, personal assistance services and IADLs, required to maintain the individual in his home and community and initially developed by the RMS or its contractor for services provided under the Home and Community-Based Services Waiver.
32. **Instrumental Activities of Daily Living (IADLs).** Meal preparation, money management, transportation, shopping, using the telephone, medication management, heavy housework, and light housework.
33. **Legal Guardian/Conservator.** A court-appointed individual who manages the affairs or finances or both of another who has been found to be incapable of handling his own affairs.
34. **Legal Representative.** A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions.
35. **Medical Necessity.** A service is medically necessary if (a) it is reasonably calculated to prevent, diagnose, or treat conditions in the client that endanger life, cause pain, or cause functionally significant deformity or malfunction and (b) there is no other equally effective course of treatment available or suitable for the client requesting the service which is more conservative or substantially less costly.
36. **Neglect.** The negligent failure to provide those goods or services which are reasonably necessary to sustain the life and health of a person.
37. **Negotiated Service Agreement.** The agreement between the resident and /or their representative and the facility/CFH based on the assessment, physician's or authorized provider's orders, if any, admission records, if any, and desires of the resident, and which outlines services to be provided and the obligations of the facility/CFH and the resident.
38. **Nursing Services.** Intermittent or continuous oversight, training, or skilled care which is within the scope of the

Nurse Practice Act and, as such, care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho.

39. **Participant.** An individual who is receiving Medical Assistance.
40. **Personal Assistance Agency.** An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, is the employer of record and in fact, and may provide fiscal intermediary services.
41. **Personal Emergency Response Systems (PERS).** A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems.
42. **Provider Agreement.** An agreement between the provider and the Department, entered into pursuant to Section 040.
43. **Provider Reimbursement Manual.** IDAPA 16.03.10, "Rules governing Provider Reimbursement in Idaho".
44. **Regional Nurse Reviewer.** A registered nurse who reviews and makes determinations on applications for entitlement to and continues participation in Title XIX long term care for the Department.
45. **Residential Habilitation.** Services consisting of an integrated array of individually-tailored services and supports furnished to an eligible participant which are designed to assist them to reside successfully in their own homes, with their families, or alternate family home.
46. **Residential Assisted Living Facility.** One (1) or more buildings constituting a facility or residence, however named, operated on either a profit or non-profit basis, for the purpose of providing twenty-four (24) hour care for three (3) or more adults who need personal care or assistance and supervision essential for sustaining activities of daily living or for the protection of the individual.
47. **Respite Care Services.** Occasional breaks from care giving responsibilities to non-paid caregivers.
48. **Room and Board.** Lodging and meals.
49. **Rule.** A requirement established by state, federal, or local government under the law and having the effect of law.
50. **Self-Declaration.** An individual's request for the criminal history check to be done authorizing the Department to obtain information and release it as required in accordance with applicable state and federal law. The form is signed

under penalty of perjury that contains the name, address, social security number and date of birth which appears on a valid identification document issued by a governmental entity.

51. **Self Reliance Specialist.** Self reliance specialist employed by the state of Idaho, Department of Health and Welfare, whose duties include the determination of eligibility and payment of Medicaid benefits.
52. **Service Coordinator.** An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under IDAPA 16.03.09, Section 118 and includes Targeted Service Coordinators.
53. **Service Plan.** A plan that describes the type and quantity of services that will be provided to a client, whether called a plan of care, plan for care, negotiated services agreement, individual support plan, or by some other name.
54. **Significant Change In Client's Condition.** A major change in the client's status that affects more than one area of the client's functional or health status, and requires review or revision of the care plan or negotiated service agreement.
55. **Social Security Act.** 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria.
56. **Supervision.** Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery.
57. **Supported Living Services.** Assistance with activities of daily living, instrumental activities of daily living, and supervision to enable a client to reside safely in the setting of the client's choice.
58. **Supported Living Services Provider.** A facility or person that provides supported living services which include nursing facilities, licensed residential and assisted living facilities, certified family homes, specialized family homes, personal care service providers, semi-independent facilities, intermediate care facilities for persons with mental retardation, and home and community-based services waiver providers.
59. **Supports.** Formal or informal services and activities not paid for by the Department that enables the individual to reside safely and effectively in the setting of his choice.
60. **Title XVIII.** Program established by the 1965 Social Security Act authorizing funding for the Medicare Program for the aged, blind, and disabled.

61. **Title XIX.** Program established by the 1965 Social Security Act authorizing the Medical Assistance Program, commonly referred to as “Medicaid”, which is jointly financed by the federal and state governments and administered by the states.
62. **Uniform Assessment or Uniform Assessment Instrument (UAI).** A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities. For participants using the Developmental Disabilities and Idaho State School and Hospital Waiver services, adults using Developmental Disability Agencies' services, and Targeted Service Coordinator services, the Uniform Assessment is the Care Management-required testing and history under IDAPA 16.03.13, “Prior Authorization for Behavioral Health Services”.
63. **Waiver Services for Aged or Disabled Adults (Home and Community Based Services).** Services to eligible participants to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage individual choice and to achieve and maintain community integration.

2.4 Abbreviations

This section defines common abbreviations that may be found in Regional Medicaid Services documentation and forms.

- **AC** Before Meals
- **AMB** Ambulatory
- **BID** Two times a Day
- **BKA** Below the Knee Amputation
- **BP** Blood Pressure
- **C** With
- **CA** Cancer
- **CABG** Coronary Artery Bypass Graft
- **CG** Caregiver
- **CHF** Congestive Heart Failure
- **COPD** Chronic Obstructive Pulmonary Disease
- **CVA** Cerebral Vascular Accident (stroke)
- **DDA** Developmental Disability Agency
- **DM** Diabetes Mellitus
- **DME** Durable Medical Equipment
- **DOB** Date of Birth
- **DOS** Date of Service.

- **DX** Diagnosis
- **EPSDT** Early and Periodic Screening, Diagnosis, and Treatment
- **ETOH** Alcohol
- **FWW** Front Wheeled Walker
- **GERD** Gastro Esophageal Reflux Disease
- **HS** Bedtime
- **HTN** Hypertension (High Blood Pressure)
- **I** Independent
- **IDAPA** Idaho Administrative Procedures Act
- **IEP** Individual Education Plan
- **ISP** Individual Service Plan.
- **LE** Lower Extremity
- **MAID** Medical Assistance Identification Card
- **MAVIS** Medicaid Automated Voice Information Service.
- **MI** Mental Illness
- **MID** Medicaid Identification Number
- **MR** Mental Retardation
- **MS** Multiple Sclerosis
- **NF** Nursing Facility
- **NPO** Nothing by Mouth
- **NWB** Non-Weight Bearing
- **OD** Right Eye
- **OS** Left Eye
- **OT** Occupational Therapy
- **OTC** Over the Counter
- **OU** Both Eyes
- **PA** Prior Authorization
- **PC** After Meals
- **PCP** Primary Care Physician
- **PO** By mouth
- **POS** Place of Service.
- **PRN** As needed
- **PT** Physical Therapy
- **Q** Every
- **QID** Four times a Day
- **RA** Rheumatoid Arthritis
- **Res. Hab.** Residential Habilitation
- **RMS** Regional Medicaid Services
- **ROM** Range of Motion.
- **S** Without
- **S/O** Significant Other
- **S/P** Status Post or After

- **S/UR** Surveillance and Utilization Review
- **SBA** Stand-By-Assist
- **SOB** Shortness of Breath
- **ST** Speech Therapy
- **TBI** Traumatic Brain Injury
- **TIA** Trans Ischemic Attack
- **TID** Three times a Day
- **TX** Treatment
- **UE** Upper Extremity
- **UNG** Ointment
- **WC** Wheelchair

Chapter 3 Medicaid Eligibility

3.1 Medicaid Eligibility

Medicaid is a health insurance program that can pay for medically necessary health care services. The Medicaid program uses a combination of state and federal government money to pay for these services. Each state has a separate Medicaid program with different rules and services. Eligibility is based on income, assets, age and/or disability.

- Medicaid rule changes and services can affect eligibility. The most current information is the official text of Department of Health and Welfare rules published in the Idaho Administrative Code. Changes to the Idaho Administrative Code are published in the Idaho Administrative bulletin which can be found on the Internet at http://www2.state.d.us/adm/adminrules/rules/idapa16/0309/pdf

3.2 Differences Between Medicaid and Medicare

Medicaid and Medicare are often confused. Medicaid is a state run program. Medicare is a federal program. The state of Idaho has no control or influence on who and what Medicare covers.

Medicaid is a program managed by the Idaho Department of Health and Welfare that pays for the health care coverage of certain groups of Idaho residents. These groups include:

- Individuals with disabilities;
- Low income working families and children
- Low income pregnant women

Medicare is a program managed by the Centers for Medicare and Medicaid Services (CMS) and provides health insurance for the following:

- People age 65 or older;
- People with disabilities who are under age 65;
- People of any age who have kidney failure or long term kidney disease

3.3 Home and Community Based Services (HCBS) Eligibility

Eligibility for Home and Community Based Services [i.e. Aged and Disabled Waiver (A & D Waiver), Developmental Disabilities Waiver (DD Waiver), and Personal Care Services (PCS)] is determined through a two (2) part process.

The first part of the process involves determining the participant ***financially*** eligible for Medicaid. To determine financial eligibility Medicaid counts income (money the participant and their spouse have coming in) and resources (things the participant and their spouse own). There are two ways to count income and resources – the ***SSI Method*** and the ***Community Property Method***:

- The ***SSI Method*** counts income received in a person's name as income. This is also known as the "name on the check" rule.
- The ***Community Property Method*** evenly divides income between the spouses, no matter whose name is on the check. Resources are counted the same way.

The best method to choose for determining income depends on the amount of income and resources owned by the participant and spouse as separate property and the amount owned jointly as community property. A participant should talk with their Self Reliance worker if they have questions about their choice and how it can affect their financial eligibility for Medicaid.

Financial eligibility for Medicaid provides the participant with a medical card to pay for medically necessary health care services ***only.*** Financial eligibility does not guarantee approval for Home and Community Based Services (i.e. Residential Assisted Living Facilities, in-home care). To qualify for Home and Community Based Services the participant must also be determined ***medically*** eligible.

For a client to be medically eligible for Medicaid payment of waiver services, Regional Medicaid Services (RMS) must determine that all of the following criteria are met:

- The participant requires services due to a physical or cognitive disability, which results in a significant impairment in functional independence as demonstrated by the findings of a Uniform Assessment Instrument

(UAI) or Scales of Independent Behavior—Revised (SIBR).
- The participant is capable of being maintained safely and effectively in a non-institutional setting.
- The participant would need to reside in a nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR) in the absence of waiver services. Medicaid program expenditures for the care of the person in the community will be no more than Medicaid program costs would be for that person's care in a nursing facility or ICF/MR.

For a client to be eligible for Medicaid payment of Personal Care Services (PCS), RMS must determine the following:

- Participant requires personal care services due to a medical condition which impairs their physical or mental function or independence.
- The participant is capable of being maintained safely and effectively in a non-institutional setting.

A participant must be determined ***both*** financially and medically eligible to be approved for Home and Community Based Services.

Chapter 4 Health & Welfare Organizational Overview

4.1 Idaho Department of Health and Welfare History

In 1907, the Idaho Legislature created the State Board of Health. From the beginning, the Board was concerned with public health in the broadest sense. The Board was replaced in 1919 by the Department of Public Welfare, which included public health and social programs. In 1941, the state created the departments of Public Health, Public Assistance, and Charitable Institutions. These programs continued to evolve under various names and organizations.

In 1974, all programs and activities were consolidated within the Department of Health and Welfare. The Board of Health and Welfare, in its current form, was created at the same time.

4.2 Idaho Department of Health and Welfare Divisions

The Idaho Department of Health and Welfare is organized into 7 Divisions. Central Offices for each Division are located in Boise and regional operations are located in the 7 Regional Offices located throughout the state.

The 4 Divisions responsible for services and programs are:

1. **Division of Family and Community Services:** The Division of Family and Community Services directs state social service programs, including adoptions, substance abuse treatment and prevention, child protection, licensure of children's care facilities, children's mental health, and the interstate compact on children. It also oversees administration, operation and program development for statewide services for mental health, developmental disabilities, and institutional programs.

2. **Division of Health:** The Division of Health provides an array of services ranging from immunizations to food safety, and emergency medical services to testing for communicable diseases. The division's programs and services actively promote healthy lifestyles, while monitoring diseases and health risks to safeguard Idaho citizens.

3. **Division of Medicaid:** The Division of Medicaid designs, implements and reviews state-funded medical assistance

services. The Division also is responsible for reimbursement to providers, provider licensure and survey, and Medicaid utilization review and fraud control.

4. **Division of Welfare:** The Division of Welfare administers various programs that serve individuals and families with low-incomes and those in crisis situations to help them become and remain self-reliant members of Idaho.

The remaining Divisions include:

5. **Management Services Division**: Provides administrative services to support the department's programs and goals. It manages the Department's budget, cash flow, oversees accounting and reporting, manages physical assets, provides fraud investigation services and processes all payroll actions.

6. **Division of Information and Technology Services**: Provides support to the Department's programs to ensure effective service delivery and efficient use of automated system resources.

7. **Human Resources Division**: Provides support and human resource services to attract, retain, and develop employees.

4.3 Division of Medicaid Organization

The Division of Medicaid is organized by Unit and Bureau as described below:

- **Administration:** Administration is responsible for Medicaid's administrative functions. The unit includes the Administrator, Deputy Administrators, Medical Director, Administrative Support Staff, Data and Finance Operations and the Quality Improvement/Quality Assurance and Training functions of the Division.

- **Bureau of Medicaid Policy**: This Bureau is responsible for policy guidance and interpretation, administration of Medicaid's waivers, support for the Healthy Connections program, coordination of the Children's Health Insurance program, (CHIP), management of provider reimbursement systems, and is the point of contact for the Automated Medicaid Information System, (AIM).

- **Bureau of Facility Standards**: This Bureau is responsible for development and enforcement of health facility standards through licensing and certification.

- **Bureau of Care Management**: This Bureau is responsible for managing and authorizing services in the state's Medical, Dental, Pharmacy, Early and Periodic Screening, Diagnosis and Treatment, (EPSDT), Durable Medical Equipment, and Mental Health and Behavioral Programs.

- **Bureau of Operations**: This Bureau is responsible for developing and monitoring contracts, managing the Medicaid Transportation program, the Third Party Recovery Program, (TRP), and the Estate Recovery Programs.

4.4 Regional Offices

There are seven regions in the state strategically placed to best serve the citizens of Idaho. Each division described above may be represented regionally and each provides a variety of services and programs.

1. **Region 1** serves the following counties: Boundary, Bonner, Kootenai, Shoshone, and Benewah. The regional office is located in Coeur d'Alene.

2. **Region 2** serves the following counties: Latah, Nez Perce, Lewis, Clearwater, and Idaho. The regional office is located in Lewiston.

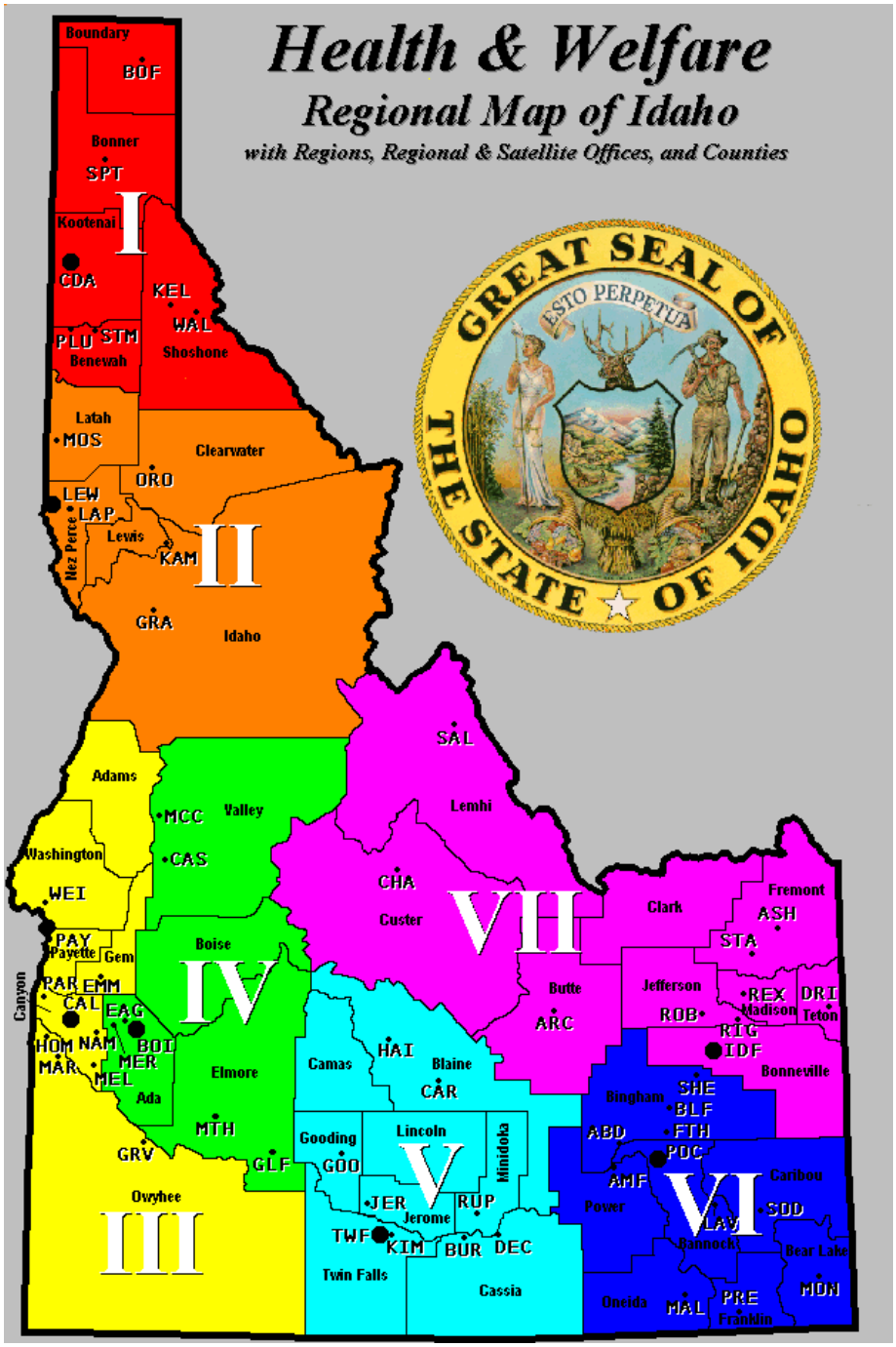
3. **Region 3** serves the following counties: Adams, Washington, Payette, Gem, Canyon, and Owyhee. The regional office is located in Caldwell.

4. **Region 4** serves the following counties: Valley, Boise, Ada, and Elmore. The regional office is located in Boise.

5. **Region 5** serves the following counties: Camas, Blain, Gooding, Lincoln, Jerome, Minidoka, Twin Falls and Cassia. The regional office is in Twin Falls.

6. **Region 6** serves the following counties: Bingham, Power, Bannock, Caribou, Bear Lake, Franklin, and Oneida. The regional office is located in Pocatello.

7. **Region 7** serves the following counties: Lemhi, Custer, Butte, Clark, Fremont, Jefferson, Madison, Teton, and Bonneville. The regional office is located in Idaho Falls.



Chapter 5 Idaho Medicaid Provider Agreement

5.1 Provider Agreement Overview

Providers of Idaho Medicaid services are required to sign and comply with a Medicaid Provider Agreement. This agreement defines provider standards and identifies relevant Idaho State Administrative Code, (IDAPA), Idaho Statute, and Federal law. Depending on the Provider Type and Service Specialty, the provider may also be required to enter into Additional Terms Agreements.

Following is an overview of the Idaho Medicaid Provider Agreement:

5.2 Compliance

The Medicaid Provider agrees to provide services in accordance with all statues, rules and federal regulations including:

- Idaho Administrative Code 16.03.09,
  Rules Governing the Medical Assistance Program.
  http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

- Idaho Administrative Code 16.03.10,
  Rules Governing Medicaid Provider Reimbursement in Idaho.
  http://www2.state.id.us/adm/adminrules/rules/idapa16/0310.pdf

- Idaho Medicaid Provider Handbook,
  http://www2.state.id.us/dhw/medicaid/provhb/index.htm

- Idaho Medicaid Information Releases,
  http://www2.state.id.us/dhw/medicaid/provhb/index.htm

- Medicaid Provider Additional Agreements when applicable

The Provider specifically agrees to comply with:

- Health Insurance Portability and Accountability Act (HIPAA)
  United States Department of Health and Human Services, Medicaid Privacy – National Standards to Protect the Privacy of Personal Health Information
  http://www.hhs.gov/ocr/hipaa/

- Health Insurance Portability and Accountability Act of 1996 Public Law 104-191, Sections 262 and 264.
  http://aspe.hhs.gov/admnsimp/pl104191.htm

- United States Code 42, Section 1320d http://uscode.house.gov/usc.htm (United States Code Search Page)

- Code of Federal Regulation, (CFR), 45 Parts 160 and 164 and 45 CFR Section 164.506 http://www.gpoaccess.gov/cfr/index.html (Code of Federal Regulations, CFR, Main Search Page.

The Provider agrees to comply with any amendments to HIPAA and federal regulations made during the term of the provider agreement.

5.3. Contact

The Provider must keep the Department current on address and change in ownership. The address must include a physical street address. If a P.O. Box is used, the owner's home address and phone number must be included. All correspondence shall be sent to the mailing address on file with the State's fiscal agent (E.D.S., Electronic Data Systems Corporation), and the Regional Medicaid Services office if applicable.

5.4 Professionalism

The Provider must be licensed, certified or registered with the appropriate State authority. All staff must have the appropriate license or certification. Paraprofessionals must be professionally supervised.

5.5 Fairness

Medicaid providers must comply with the 1964 Civil Right Act and the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act and the Vietnam Era Veterans Readjustment Assistance Act.

- Titles VI and VII of the 1964 Civil Rights Act http://usinfo.state.gov/usa/infousa/laws/majorlaw/civilr19.htm

- Sections 503 and 504 or the Rehabilitation Act of 1973 Section 503: http://www.dol.gov/esa/regs/compliance/ofccp/fs503.htm Section 504: http://www.dol.gov/oasam/regs/statutes/sec504.htm

- Americans with Disabilities Act http://www.usdoj.gov/crt/ada/pubs/ada.txt

- Vietnam Era Veterans Readjustment Assistance Act, Section 402
  http://www.labor.gov/esa/regs/compliance/ofccp/ca_vevraa.htm

5.6 Recordkeeping

The Provider must document each item or service for which Medicaid payment is claimed, at the time it is provided. ***The records of these services must be kept for at least five (5) years after the date of services.*** The Provider must provide immediate access to the records upon request from the Department, the U.S. Department of Health and Human Services or their agencies. These records may be reviewed and copied by these entities.

5.7 Accurate Billing

By signing a claim form or transmittal document the Provider or designee certifies that the items or services claimed were actually provided and medically necessary, were documented at the time they were provided and were provided in accordance with professionally recognized standards of health care, applicable Department rules and the provider agreement. The Provider is solely responsible for the accuracy of the claims submitted. *The Provider shall immediately repay the Department for any items or services the Department or the Provider determined were not properly provided, documented or claimed.* The Provider must assure they are not submitting a duplicate claim under another program or provider type.

5.8 Secondary Payer

The Provider acknowledges that Medicaid is a secondary payer and agrees to first seek payment from other sources as required by rule, regulation, or statute.

5.9 Full payment

The Provider agrees to accept Medicaid payment for any item or services as payment in full. In addition:

- The Provider must obtain *prior authorization* for those items or services where it is required. The provider will not bill Medicaid or the client if the request for prior authorization is not timely submitted.

- The Provider will not bill the client unless the item or service is not covered or approved for payment by Medicaid and the client agreed to be responsible for payment before they received the item or service.

Medicaid may recoup from the Provider up to three (3) times any amount the Provider charges a Medicaid client. Medicaid will not be billed if a third party pays the client. The Provider may then bill the client for that amount. The Provider will not bill Medicaid or the client if a third party payment is made to the Provider unless the third party payment is less than the amount Medicaid would pay. The Provider shall not refuse to furnish services based on a third party's potential liability for the services.

- See 42 CFR Part 447.20
  http://www.gpoaccess.gov/cfr/index.html
  (Code of Federal Regulations, CFR, Main Search Page).

5.10 Service Providers

The Provider is responsible for recruiting, hiring, firing, training, supervision, scheduling and payroll for its employees, subcontractors or agents. The Provider will maintain general liability insurance coverage, worker's compensation and unemployment insurance, and will pay all FICA taxes and state and federal tax withholdings for its employees. The Provider will only bill for service providers who have the qualifications required for the type of service that is being delivered.

5.11 Ownership

The Provider will comply with the disclosure of ownership requirements when applicable and will notify the Department thirty (30) days prior to any change of ownership. The Provider Agreement is not transferable.

- 42 CFR Part 455, Subpart B and 42 CFR Part 411.261
  http://www.gpoaccess.gov/cfr/index.html
  (Code of Federal Regulations, CFR, Main Search Page).

5.12 Advance Directives

The Provider will comply with the advance directives requirement when applicable.

- 42 CFR Part 489, Subpart 1 and 42 CFR 417.436 (D)
  http://www.gpoaccess.gov/cfr/index.html
  (Code of Federal Regulations, CFR, Main Search Page).

5.13 Confidentiality

The Provider will protect the confidentiality of identifying information that is collected, used or maintained about a client. Confidential information will only be released with appropriate written authorization of the client

- Idaho Administrative Code 16.05.01, "Use and Disclosure of Department Records"

http://www2.state.id.us/adm/adminrules/rules/idapa16/0501.pdf

- 42 CFR section 431.300
  http://www.gpoaccess.gov/cfr/index.html
  (Code of Federal Regulations, CFR, Main Search Page).

5.14 Officers and Employees Not Liable

No official, employee or agent of the State of Idaho can be held personally liable or responsible for any term of the Provider Agreement.

5.15 Duration and Termination of Agreement

The Provider agreement will remain in effect until terminated in writing. If the Department terminates the agreement, the Department is only responsible to pay for services prior to the effective date of the termination. The Department is not responsible for any costs or expenditures of the provider in reliance upon the terms of the agreement.

- The agreement may be terminated by either party without cause by giving thirty (30) days notice in writing to the other party.

- The Provider Agreement will be terminated immediately if the Provider's license or certification required by law is suspended, not renewed or is otherwise not in effect at the time service is provided.

- The Department may terminate the agreement in writing when the Provider fails to comply with any applicable rule, term or provision of the agreement. The termination may be immediate or at some other time interval deemed appropriate by the Department. The Provider's conduct may be subject to additional penalties or sanctions.

    - Idaho Code Sections 56-227, 56-227A, 56-227B and 56-209(h), Title 56, Public Assistance and Welfare, Chapter 2, Public Assistance Law
      http://www3.state.id.us/idstat/TOC/56002KTOC.html

    - IDAPA 16.03.09.200-224, as amended
      http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

There are federal penalties for false reporting and fraudulent acts committed during the course and scope of this agreement. Notice of these sections in no way implies that they represent

an exclusive or exhaustive list of available actions to deal with fraud and abuse.

Chapter 6 General Billing Guidelines

6.1 General Billing Guidelines

The Idaho Medicaid Provider Handbook can be viewed at the following Internet address and provides detailed and specific information about Medicaid billing processes:
http://www2.state.id.us/dhw/medicaid/provhb/index.htm

Once enrolled as an Idaho Medicaid provider, providers are eligible to bill for services rendered to Idaho Medicaid participants. Provider enrollment only signifies that a provider may bill Medicaid. It does not guarantee authorization of service delivery to a particular participant.

A participant may become ineligible for Medicaid at any point in time. Although the participant receives notice ten (10) days prior to their Medicaid coverage being terminated, their provider agency does not receive notification. To ensure your claims for payment are not denied based on a participant's ineligibility, it is important to verify eligibility at the time services are rendered.

Providers must accept payment from Medicaid as payment in full for services rendered if they bill Medicaid for covered services. Medicaid requires the provider to inform the participant prior to rendering service if a particular service will not be billed to Medicaid, preferably in writing. If the participant agrees to pay for the service prior to the delivery of the service, then the provider may bill the participant for the entire amount of the fee.

6.2 Timely Filing Limit

All claims must be submitted within one (1) year [365 days] from the date the service is delivered. This is referred to as "timely filing".

6.3 Claims Submission

Providers may submit claims either electronically (EDI) or on paper (hardcopy).

The State's Medicaid Fiscal Agent, EDS, provides free software for billing electronically. If a provider wants to use billing software other than that provided free-of-charge by EDS, they will need to have their software vendor or clearinghouse contact EDS to test software before claims can be submitted.

Paper claim forms can also be used for billing. The printed versions of the claim forms are "machine readable" (scannable). As such, they are printed using special paper, special color inks, and within precise specifications. For this reason, only **original, color forms** can be used for scanning. Forms that cannot be scanned are returned to the provider.

6.4 Provider Signature

Providers must sign every claim form ***or*** complete a signature-on-file form. This form is used to submit paper claims without a signature. This form allows submission of claims without a handwritten signature. It is used for computer-generated, signature stamp, or typewritten signatures.

6.5 Provider Number

No claim can be processed without a valid Idaho Medicaid provider identification number. At the time of enrollment, each individual and group provider receives a unique number to use in the Idaho Medicaid program. Provider identification numbers always have nine (9) digits with **no** spaces or hyphenation. Do **not** use a Social Security or FEIN number.

6.6 Prior Authorization

Federal regulations permit Medicaid to require prior authorization (PA) for any service. Effective October 20, 2003, all claims for all services that require prior authorization must include the PA number on the claim whether the claim is electronic or paper.

When prior authorization for a Medicaid service is required, Medicaid issues a written notification of PA to the authorized provider. The PA letter indicates the length of time the authorization is valid. The dates of service being billed must occur after the start date and before the expiration date indicated on the PA letter. To prevent a disruption or break in service to the participant, request prior authorization as soon as the need for additional services is identified.

6.7 Adjustments

When a claim is paid incorrectly, submit an adjustment request to EDS. Incorrect payments may result from changes to information received after initial payment, provider billing errors or claims processing errors. Only claims listed on the "Paid Claims" section of a remittance advice (RA) can be adjusted.

Providers have two (2) years from the date of service to request an adjustment. In accordance with the provider agreement, providers are required to immediately repay identified overpayments.

Chapter 7 Criminal History Requirements

7.1 Mandatory Criminal History Checks

Idaho Criminal History rules require certain persons to complete a "self-declaration form and fingerprinting" before they may provide Department funded care and/or services. Any agency allowing persons to provide care or services before this requirement is satisfied may be subject to corrective action, recoupment of funds, provider agreement termination, and/or other Department imposed action.

The Rules Governing Mandatory Criminal History Checks, (IDAPA 16.05.06), should be reviewed in their entirety.

- Idaho Administrative Code 16.05.06
  Rules Governing Mandatory Criminal History Checks"
  http://www2.state.id.us/adm/adminrules/rules/idapa16/0506.pdf

The Idaho Department of Health and Welfare, Division of Management Services, Criminal History Unit manages the criminal history check process.

Fingerprinting, self-declaration completion, and payment of associated fees are managed in the seven Department designated regions in the State.

- Regional office telephone numbers can be accessed at the following website:
  http://www2.state.id.us/dhw/Directory/regions.htm

The Criminal History Unit central office is located in Nampa, Idaho., (208) 465-8408.

7.2 Individuals Subject to Mandatory Criminal History Checks

IDAPA 16.05.06.015.02 states, "A self-declaration and a criminal history check shall be required of other individuals, including providers and contractors and their employees, volunteers, and student interns and any other persons, who provide Department funded direct care or services to children or vulnerable adults as defined in Section 39-5302(10), Idaho Code. These include but are not limited to:

- Providers of personal care, *excluding employees of nursing homes and licensed residential and assisted living facilities*;

- Adult family home care providers and all adults in the home or living on the property;

- Children's foster home care providers and other individual(s) age eighteen (18) or older residing in the foster care provider's home or property;

- Providers of adult day care and all adults in the home, if provided in a private residence;

- Providers of children's day care and all other individuals over twelve (12) years of age in the day care who have unsupervised contact with children;

- Adult residential care facility owners, operators, and administrators;

- Personnel of children's residential care facilities;

- Providers in adult day treatment facilities;

- Personnel of agencies with Medicaid Provider Agreements or Department contracts who have direct contact with children or vulnerable adults;

- All persons applying to the Department to be an adoptive parent except step-parents applying for adoption of a step-child;

- All persons petitioning the court for adoption of a child except in the case of a step-parent adoption or when waived by the court; and

- Applicants for EMS certification and EMS communications specialists and managers."

Vulnerable adults is defined in Idaho Statute 39-5302(10) as "…a person eighteen (18) ears of age or older who is unable to protect himself from abuse, neglect or exploitation due to physical or mental impairment which affects the person's judgment or behavior to the extent that he lacks sufficient understanding or capacity to make or communicate or implement decisions regarding his person…"

- Additional Adult Abuse, Neglect and Exploitation Act information, (Idaho Code Title 39, Chapter 53), can be accessed at the following website link: http://www3.state.id.us/idstat/TOC/39053KTOC.html

Fees for Criminal History checks are defined in IDAPA 16.05.06.018, (Fees and Costs).

7.3 Initial and Update Timeframes for Criminal History Checks

The Criminal History Rules require that all individuals covered by these rules complete a self-declaration form and fingerprinting ***prior*** to providing unsupervised direct care or services to children or vulnerable adults.

If an individual covered under these rules accepts employment with a new employer or agency providing Department funded direct care or services, and the criminal history check was completed more than (1) year from the date of the new employment, a new Criminal History Check is required.

7.4 Unconditional Denials, Conditional Denials, and Exemption Reviews

When a criminal history check reveals that the applicant has pled guilty, been found guilty, or has been adjudicated of one of the designated crimes listed in IDAPA 16.05.06.030, an automatic unconditional denial is made. IDAPA 16.05.06.030.03 further lists “designated seven-year crimes.” In instances when a designated seven year crime is revealed on the applicants criminal history check, for seven years from the date of conviction, an unconditional denial shall be issued.

In the case of other certain crimes, or when the applicant has falsified or omitted information on the self-declaration form, the Department may issue a conditional denial. An individual may request an exemption review within certain time frames when a conditional denial is issued. When an exemption review is requested, the Department may review documents and supplemental information provided by the individual in order to determine whether or not to grant an exemption allowing the individual to provide Department funded care and/or services.

Chapter 8 Advance Directives and Participant Rights

8.1 Advance Directives and Participant Rights Defined

Certain Medicaid providers may be required to notify participants of rights and advance directive options.

An **Advance Directive** is defined in 42 CFR, Chapter IV, Part 489, Subpart I, Section 489.100 as, "…a written instruction, such as a living will or durable power of attorney for health care, recognized under State law, (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated."

Medicaid participant rights are specific rights and protections afforded to persons receiving Medicaid program services and are defined in certain Idaho Administrative Codes.

8.2 Advance Directives

Section 11 of the Medicaid Provider Agreement requires Medicaid Providers to comply with advance directive requirements when applicable. Idaho Administrative Code 16.03.09.021 provides specific information and procedures regarding advance directive requirements.
http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

Providers required to comply with advance directive requirements include hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care, (and for Medicaid purposes, providers of personal care services), and hospices must maintain written polices and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the provider…" (42 CFR, Part 489, Subpart I, Section 489.102).
http://www.gpoaccess.gov/cfr/index.html
(Code of Federal Regulations, CFR, Main Search Page).

8.3 Participant Rights

In some instances, Medicaid Providers must insure Medicaid Participants have been made aware of certain rights and protections. Following are references from specific Idaho Administrative Code:

- Idaho Administrative Code 16.03.22.250, (Rules for Licensed Residential or Assisted Living Facilities in

Idaho,) states, "Resident's Rights. Each facility shall develop and implement a written residents' rights policy which shall protect and promote the rights of each resident…"
http://www2.state.id.us/adm/adminrules/rules/idapa16/0322.pdf

- Idaho Administrative Code 16.04.17.402, (Rules Governing Residential Habilitation Agencies), states, "Responsibilities. Each residential habilitation agency must develop and implement a written policy outlining the personal, civil, and human rights of all participants. The policy protects and promotes the rights of each participant…"
http://www2.state.id.us/adm/adminrules/rules/idapa16/0417.pdf

- Idaho Administrative Code 16.03.19.200, (Rules Governing Certified Family Homes), states, "Residents' Rights Policy. Each certified family home shall develop and implement a written residents' rights policy which shall protect and promote the rights of each resident…"
http://www2.state.id.us/adm/adminrules/rules/idapa16/0319.pdf

- Idaho Administrative Code 16.03.11.075, (Rules Governing Intermediate Care Facilities for the Mentally Retarded, (ICF/MR), states, "The administrator of the facility shall be responsible for the establishment of and adherence to written policies and procedures pertaining to the rights and responsibilities of residents. If a resident has been determined to be incompetent or incapable of understanding his rights or responsibilities, these same rights and responsibilities shall devolve to the resident's parent, legal guardian or representative. Each resident admitted to the facility must be assured of the following rights…"
http://www2.state.id.us/adm/adminrules/rules/idapa16/0311.pdf

This is not an exhaustive list of Medicaid Participant right references. Other Idaho Administrative Code may also define specific resident right requirements.

Chapter 9 Complaints and Reporting Requirements

9.1 Complaints

It is the policy of the Idaho Department of Health and Welfare to investigate complaints to ensure that Medicaid participants are not subject to abuse, neglect, exploitation, or improper care, that Medicaid fraud and abuse does not occur, and that Medicaid Providers operate within provider agreement requirements.

Complaint types may include, but are not limited to, poor or improper services and care provision, abuse, exploitation, neglect, misconduct, unprofessional behavior, poor supervision, lack of training, and fraudulent billing. It is critical that complaints are dealt with in an expedient manner, to include timely and legal reporting to proper authorities when required, and that standard investigation, documentation and follow-up activities are adhered to.

9.2 Medicaid Provider Complaint and Reporting Requirements

Depending on the Medicaid Provider Agreement and, if applicable, the Additional Terms Agreement, a Provider may be required to develop complaint management and reporting policies. Complaint policies may include procedures to investigate, document and report complaints, and what corrective and follow up actions will be taken.

Depending on the nature of the complaint, the Medicaid Provider may be required to report the complaint to the Idaho Department of Health and Welfare, Law Enforcement, and/or child and adult protection agencies within specified time frames. In some instances, complaints must be immediately reported to the proper authority.

9.3 Duty to Report Cases of Abuse, Neglect or Exploitation of Vulnerable Adults.

Idaho Code 39-5303, requires that certain caregivers and professionals immediately report abuse, neglect, and exploitation of vulnerable adults to the Idaho Commission on Aging.

- Idaho Code 39-5303
  http://www3.state.id.us/idstat/TOC/39053KTOC.html

- Idaho Commission on Aging
  http://www.idahoaging.com/abouticoa/index.htm

9.4. Definitions from Idaho Code 39-5302, Adult Abuse, Neglect and Exploitation Act:

http://www3.state.id.us/idstat/TOC/39053KTOC.html

- **Abuse:** The non-accidental infliction of physical pain, injury, or mental injury.

- **Exploitation:** An action which may include, but is not limited to, the misuse of a vulnerable adult's funds, property, or resources by another person for profit or advantage.

- **Neglect:** Failure of a caretaker to provide food, clothing, shelter or medical care reasonably necessary to sustain the life and health of a vulnerable adult, or the failure of the vulnerable adult to provide those services to himself.

- **Vulnerable Adult:** A person eighteen (18) years of age or older who is unable to protect himself from abuse, neglect or exploitation due to physical or mental impairment which affects the person's judgment or behavior to the extent that he lacks sufficient understanding or capacity to make or communicate or implement decisions regarding his person.

9.5 Duty to Report Child Abuse, Abandonment or Neglect

Idaho Code 16.1619, Title 16 Juvenile Proceedings, Chapter 16 Child Protection Act, Reporting of Abuse, Abandonment or Neglect, (http://www3.state.id.us/idstat/TOC/16016KTOC.html), requires that persons who have reason to believe that a child under the age of eighteen years has been abused, abandoned, or neglected or who observes the child being subjected to conditions or circumstances which would reasonably result in abuse, abandonment or neglect, make report to law enforcement and/or to the Department of Health and Welfare within certain time frames.

9.6 Definitions from Idaho Code 16.1602, Title 16 Juvenile Proceedings, Chapter 16 Child Protection Act

http://www3.state.id.us/idstat/TOC/16016KTOC.html

- **Abused:** "Abused" means any case in which a child has been the victim of:
  - (a) Conduct or omission resulting in skin bruising, bleeding, malnutrition, burns, fracture of any bone, subdural hematoma, soft tissue swelling, failure to

thrive or death, and such condition or death is not justifiably explained, or where the history given concerning such condition or death is at variance with the degree or type of such condition or death, or the circumstances indicate that such condition or death may not be the product of an accidental occurrence; or

- (b) Sexual conduct, including rape, molestation, incest, prostitution, obscene or pornographic photographing, filming or depiction for commercial purposes, or other similar forms of sexual exploitation harming or threatening the child's health or welfare or mental injury to the child.

- **Abandoned:** "Abandoned" means the failure of the parent to maintain a normal parental relationship with his child including, but not limited to, reasonable support or regular personal contact. Failure to maintain this relationship without just cause for a period of one (1) year shall constitute prima facie evidence of abandonment.

- **Neglect:** "Neglected" means a child:
  - Who is without proper parental care and control, or subsistence, education, medical or other care or control necessary for his well-being because of the conduct or omission of his parents, guardian or other custodian or their neglect or refusal to provide them; provided, however, no child whose parent or guardian chooses for such child treatment by prayers through spiritual means alone in lieu of medical treatment, shall be deemed for that reason alone to be neglected or lack parental care necessary for his health and well-being, but further provided this subsection shall not prevent the court from acting pursuant to this section 16-1616, Idaho Code; or
  - (b) Whose parents, guardian or other custodian are unable to discharge their responsibilities to and for the child and, as a result of such inability, the child lacks the parental care necessary for his health, safety or well-being; or
  - (c) Who has been placed for care or adoption in violation of law.

Chapter 10 Safe and Effective

The mission of Idaho's Department of Health and Welfare is to promote and protect the health and safety of Idahoans. This statement guides Idaho Medicaid in administration of all our programs.

The Division of Medicaid makes assurances to the Centers for Medicare and Medicaid Services that services to participants are safe and effective. This can only be met when the health and well being of a participant is not in jeopardy. All of the partners in the health care delivery system have to make sure this occurs. That includes Idaho Medicaid, the Provider Agency, and the employee of the agency.

It is difficult to define safe and effective in terms of a checklist of items. Medicaid makes sure the services delivered are safe and effective in the living arrangement. The Provider Agency or their staff is present during delivery and is better able to evaluate whether the service is promoting health and safety. Each partner in the delivery system must do their part for successful outcomes.

10.2 The role of Idaho Medicaid is to:

- Consider the health and safety of the participant in authorizing services and monitoring outcomes
- Use professional judgment that services authorized meet the needs of the participant
- Determine the services are appropriate in the living situation or setting
- Identify and communicate the needs of the participant and services authorized to the provider
- Use the Quality Assurance Process to monitor ongoing service delivery

10.3 The role of the Medicaid Provider is to:

- Consider the health and safety of the participant in delivering the service and overseeing staff
- Ensure that staff are trained and capable of providing services and meet the needs of the participant
- Ensure that staff meet the provider qualifications set in rule for each service delivered
- Communicate with Medicaid staff if participant's needs change

- Monitor their employees performance in delivery of services for positive outcomes

10.4 The role of the provider staff is to:

- Consider the health and safety of the participant in personal contact and delivery of services
- Ensure they understand the needs of the participant
- Deliver service in the manner consistent with generally accepted standards of care and practice
- Communicate with the agency or Medicaid staff if participant's needs change
- Treat the participant with dignity and respect

Chapter 11 Quality Assurance Process

11.1 Quality Assurance

Quality Assurance is the method Idaho Medicaid uses for:

- Program Management
  - Check to see if services are being delivered as agreed and in a manner that is timely and appropriate
  - Data can document areas that require improvement

- Quality Improvement
  - Target areas that need priority attention
  - Show trends over time of whether a particular aspect of service is improving, unchanged or getting worse

- Accountability
  - Information to ensure quality service from each provider

11.2 Provider Quality Assurance

Provider agencies are responsible for:

- Training and supervision of their employees, subcontractors or agents
  - Compliance with state and federal regulations Accountability
  - Assurance of safe and effective services
  - Compliance with all provider agreement conditions

Each agency should have in place a set of policies and procedures to monitor theses responsibilities.

Agencies can use several resources to help them determine how best to deliver quality services and know what the Department will expect to see in a review process.

- Idaho Administrative Rules that apply to the services you provide

- Provider agreement for the type and specialty of your agency-these contain specific qualifications and requirements

- Health and Welfare Quality Assurance Review Form – this is what the Department will look at during the annual review process

- Provider Handbook

11.3 Department Quality Assurance

The Department will conduct a review every two years of all provider agencies. The review will verify those requirements set out in Idaho Administrative Rule and in the provider agreement. Each specific type of agency will have their own review form that looks at aspects of services provided which are unique to that type of agency.

The review process will come up with a qualitative score based on the findings of the review. This is a way for an agency to compare their work from year to year.

It is the intent of the Department to help agencies improve the quality of their service delivery. The Quality Assurance Review process will:

- Assure safe and effective services

- Identify best practices

- Set benchmarks to insure quality services

- Monitor compliance with state and federal regulations

- Identify training needs

- Identify opportunities for quality improvement

Regional Medicaid Services (RMS) will contact agencies at least 30 days prior to a review. A copy of the review form will be provided. After the review is completed, the RMS will notify the agency within 45 days of the results. At that time, if corrective action is needed based on the review, the RMS will work with the agency to complete the plan.

11.4 Ethics

Agencies are responsible for the actions of their staff. Their employees should meet current licensure or certification requirements as appropriate and follow the ethic guidelines of their governing board.

The agency should have policies and procedures for their employees concerning standards of conduct. These should include but are not limited to:

- Provide services in a respectful, courteous manner
- Respect participant's rights, including privacy and self-determination
- Neglect, abuse and harassment in any form is prohibited
- Will not become involved in the participant's personal/financial affairs
- Will not provide services while using, or under the influence of drugs or alcohol
- Ensure confidentiality of all participant information collected, used, or maintained

Chapter 12 Record Keeping

12.1 Record Keeping

In compliance with Idaho Statute 56-209(h) (2), (http://www3.state.id.us/idstat/TOC/56002KTOC.html), Medicaid requires all providers meet the documentation requirements listed in the Provider Agreement. Except as otherwise provided by rule, providers need to generate records at the time of service, sufficient in content to fully support each item or service claimed for Medicaid reimbursement.

Consult Individual Provider Program Guidelines in the Idaho Medicaid Handbook and relevant IDAPA codes for specific documentation requirements within a given program.

Providers are required to retain records to document services submitted for Medicaid reimbursement for at least 5, (five), years from date either service or item was provided.

Upon written request presented to the provider, the Department or authorized agent will be given immediate access to, and permitted to review and copy any and all records and documentation used to support claims billed to Medicaid.

“Immediate access” means access to records at the time the written request is presented to the provider.